

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2019
NAME OF PROVIDER OR SUPPLIER Reo Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6061 Banbury St. San Diego, CA 92139	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>The facility failed to provide a safe environment for 1 sampled Resident (1) when CNA 1 exposed himself and had physical intercourse (the penetration of the male sex organ into the vagina) with Resident 1.</p> <p>As a result, Resident 1 reported to staff the following morning she had been raped and was the victim of sexual abuse. This in turn resulted in the resident being sent to the hospital for examination and testing by a SART. Tests done at the hospital confirmed the presence of male sperm in the resident's vaginal area.</p> <p>Findings:</p> <p>An unannounced visit was made to the facility on [DATE] at 3:35 P.M. to investigate a facility reported incident, CNA 1 exposed himself and raped Resident 1 in her room.</p> <p>Resident 1's record was reviewed on 2/21/19.</p> <p>Resident 1, a [AGE] year- old female was admitted to the facility on [DATE], per the Resident Face Sheet. Resident 1's [DIAGNOSES REDACTED].</p> <p>According to the quarterly MDS(an assessment tool), dated 2/11/19, a reflection of the resident's status during the previous 7 days, Resident 1 required set up help and supervision to transfer from her wheelchair to her bed. The same MDS indicated Resident 1 scored 13 on the BIMS (cognitive assessment), indicating the resident was cognitively intact. Resident 1 was capable of understanding and being understood.</p> <p>The LN progress notes were reviewed. The LN progress notes, dated 2/10/19 at 7:30 A.M., indicated, Resident last night is claiming that she went to the kitchen last night to get a sandwich and on her way back one of the CNAs stated that one of her breasts was exposed., she then went to her room where the CNA followed her and he exposed his private parts to her. The CNA raped her. Resident in distress with episodes of crying .Resident requested to file a police report .Also, one of the Police Officers took the Resident to a hospital for further evaluation.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the LN progress notes, dated 2/10/19 at 8:05 P.M., Resident 1 was escorted back to the facility by the police officer from a hospital Forensic Health Services with recommendation for testing [MEDICAL CONDITION] and other [MEDICAL CONDITION]/infection.</p> <p>On 2/21/19 at 4:45 P.M., an interview was conducted with Resident 1. Resident 1 had slurred speech and was difficult to understand. Resident 1 stated she did not remember the date and time when she wheeled herself to the kitchen to get a sandwich and ice cream. She stated when she went back to her room, she placed her sandwich and ice cream on top of the bedside table and started eating. She stated while she was eating the sandwich, she heard a male staff calling her name and when she looked over her shoulder, she saw a male staff entered her room. She stated she did not know the name of the male staff. Resident 1 stated CNA 1 asked her to sit on the edge of her bed, pushed her forehead and forced her to lay down across the bed. Resident 1 stated her lower legs were over the side of the bed. She stated the male nurse pulled down her pants and placed his penis in her vagina. Resident 1 stated the male nurse continued to penetrate her for a duration of two to three minutes. Resident 1 stated the male staff put on his pants and left the room. Resident 1 stated, she did not scream, yell or fight. When asked why she did not scream, yell or fight the male staff, Resident 1 stated, I don't know. She stated she did not report the incident to any staff until the next morning when she reported the incident to the charge nurse. Resident 1 stated the police came and took her to a hospital for physical examination.</p> <p>On 2/21/19 at 5 P.M., an attempt to interview Resident 2 (roommate of Resident 1) was made. Resident 2 was in a vegetative state (absence of responsiveness and awareness) and could not be interviewed.</p> <p>On 2/21/19 at 5:45 P.M., an interview was conducted with the ADM. The ADM stated on 2/10/19, during the morning shift, Resident 1 reported CNA 1 followed her into her room and raped her on 2/9/19 between 6 P. M. and 6:30 P.M.</p> <p>On 4/22/19 at 8:20 A.M., the SDCIR, dated 2/10/19, was received from San Diego Police Department Records Division. The SDCIR indicated, SYNOPSIS: On 02-09-2019, Resident 1 was eating by her bedside at the (name of the facility) .Resident 1 is disabled and is a patient at this long term care facility. A CNA 1 entered Resident 1's room and told her to lay down in her bed. Resident 1 complied with the order by sitting down on the edge of her bed. CNA 1 then pushed Resident 1 down onto the bed by pushing her at the shoulders. CNA 1 removed Resident 1's pants and underwear and inserted his penis into her vagina. Resident 1 told CNA 1 to stop several times. CNA 1 continued to penetrate his penis into her vagina for approximately 3 to 5 minutes .</p> <p>The San Diego Police Department Forensic Science Section Forensic Biology Unit Laboratory Report, dated 3/20/19, indicated, the SART kit results showed male DNA was detected in and around the resident's vagina.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/13/19 at 7:54 A.M., a telephone call was received from CNA 1. CNA 1 stated on 2/9/19, after working on the morning shift, he signed up for overtime and worked from 3 P.M. for a few hours. CNA 1 stated around 7 P.M., he noticed Resident 1's call light was on. CNA 1 stated, This is something I regret. He stated he answered the call light and when he entered Resident 1's room he saw Resident 1 sitting in the wheelchair by the bedside table eating a tuna salad sandwich. CNA 1 stated he was standing at the foot of Resident 1's bed. CNA 1 stated he asked Resident 1 if she needed something and Resident 1 asked him to bring her some water. CNA 1 stated, Then I asked her, is there anything else you need? CNA 1 stated Resident 1 told him that her daughter needed a boyfriend. CNA 1 stated he told Resident 1 he already had a girlfriend. CNA 1 stated Resident 1 asked him to look for the television remote control on the bed. CNA 1 stated, Resident 1 was still sitting in her wheelchair at this time. CNA 1 stated when Resident 1 asked him to look for the TV remote control, Resident 1 moved her wheelchair facing him. CNA 1 stated Resident 1 tried to locked' (trapped) him. CNA 1 stated, She (Resident 1) started grabbing my private part, my penis with her hands. CNA 1 stated, Resident 1 moved herself from the wheelchair to the bed and pulled down her pants herself.</p> <p>CNA 1 stated Resident 1 was lying across her bed, her head was by the wall both her legs were over the side of the bed. CNA 1 stated, It happened. There was penetration of my penis to Resident 1's vagina. CNA 1 stated, the penetration to Resident 1 took less than five minutes. CNA 1 stated, I put on my pants, left the room and brought the water to her.</p> <p>CNA 1 stated, I feel bad. It happened so fast. I didn't think about it. I didn't think if I should do it or should not do it at that time.</p> <p>According to CNA 1'S personnel record, CNA 1 had been employed at the facility for four months. CNA 1 resigned on 2/11/19. CNA 1 completed the Elder and Dependent Adult Abuse training on 10/10/18. CNA 1 completed the training on the facility policy about Sexual Harassment on 10/10/18.</p> <p>The facility policy and procedure titled, Resident Rights and Dignity Abuse Prevention Program dated 3/2013 indicated, Our residents have the right to be free from abuse .1. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff .</p> <p>The facility failed to ensure a male CNA followed the policy and procedure related to Resident Rights and Dignity Abuse Prevention Program, when he engaged in sexual intercourse with a female resident leading to an allegation by the resident the CNA raped her. The facility did not protect Resident 1 from sexual abuse from CNA 1.</p>		